MassHealth Survey on the Managed Care Entity and Community Service Agency Interface Final Report

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MassHealth

CBHI
Children's Behavioral Health Initiative

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Purpose

As part of a continuous quality improvement effort, MassHealth, conducted a survey regarding Managed Care Entity (MCE)[1] communication processes and service authorization processes for services required under the Rosie D. Remedy. The goal of the survey was to obtain feedback from Community Service Agencies (CSAs) on the communication processes and authorization requirements of the five MCEs—Boston Medical Center Healthnet Plan (BMCHP), Fallon Community Health Plan[*], the Massachusetts Behavioral Health Partnership (MBHP), Neighborhood Health Plan* (NHP), and Network Health.

Methodology

Preliminary survey questions were developed by the Office of Behavioral Health for MassHealth and feedback on the questions was solicited from the court monitor in Rosie D. v. Patrick, the MCEs, MassHealth personnel, and the trade organization, Association for Behavioral Healthcare, which represents many of the Community Service Agencies. Feedback from these stakeholder groups was incorporated into the final survey which, in its final form, consisted of two parts. Part 1 of the survey contained 9 questions about communication processes, meeting structures and overall satisfaction with the implementation of ICC and FS&T. Part II of the survey contained 10 questions about MCE specific authorization processes and procedures. The rationale for two discrete sections was that for the most part, the CSA personnel who had the exposure and experience to rate the questions in part I of the survey (e.g. senior administrative staff, program directors, senior supervisors) are different from those with the exposure and experience to rate the questions in part II (e.g. direct care staff). Both parts of the survey contained a mix of Likert type questions and free-text fields in order to obtain both quantitative and qualitative data.

The survey was created using the online survey software, Survey Monkey. All 32 CSA providers were sent an email invitation to participate in the survey. Additionally, the individuals who received the email invitation were asked to forward the survey to other individuals within their organizations as appropriate in order to broaden the initial respondent pool to include care coordinators and family partners with experience with the authorization processes of the MCEs. The original email invitation to participate in the survey was sent on September 24, 2009 with a response deadline of October 9, 2009. Responses were completely anonymous and providers were told there was no penalty for choosing not to respond to the survey.

Please note that the number of responses varies by question as many respondents either skipped questions or responded with a "not applicable". As the survey was broken-down into two sections respondents made differential decisions about which questions to answer based the relevancy of the question given their role in the organization.

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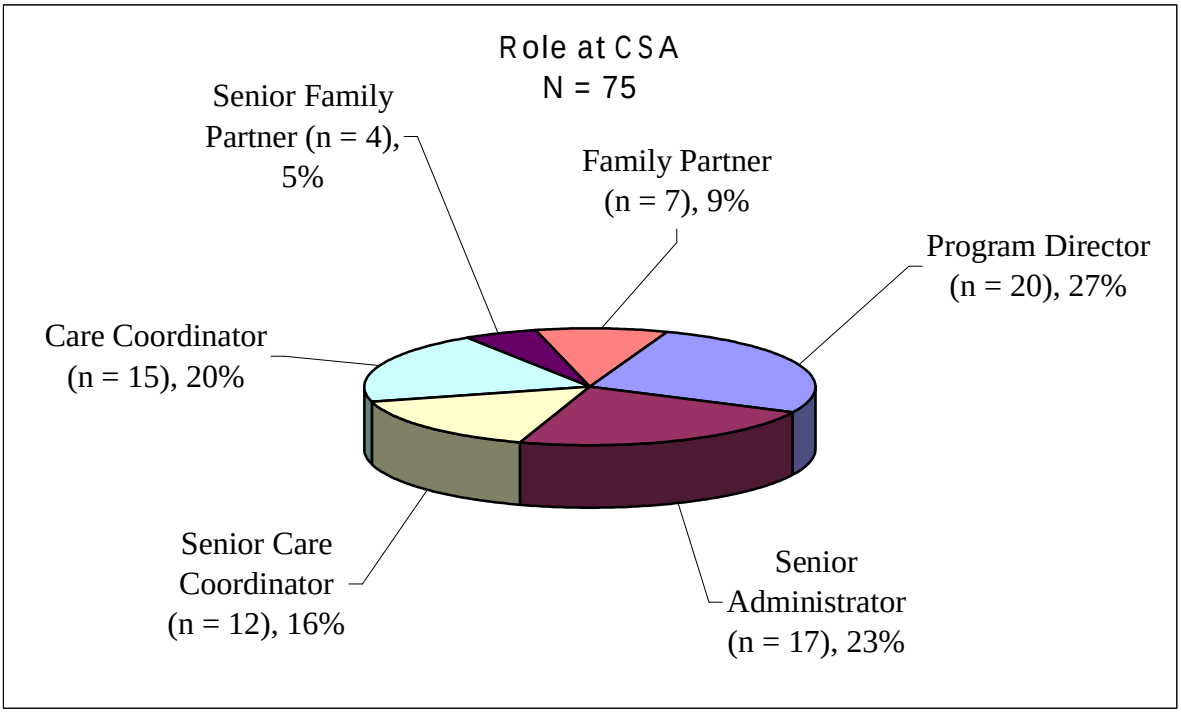
[1] Managed Care Organization (MCO) is used to refer to the four MassHealth contracted Managed Care Organizations which are BMCHP, Fallon, NHP, and Network Health. The term Managed Care Entity (MCE) is more comprehensive and used to refer to the four MCOs and the PCC plan behavioral health carve-out vendor, MBHP.

[*] Beacon Health Strategies is the behavioral health subcontractor for Fallon Community Health Plan and Neighborhood Health Plan.

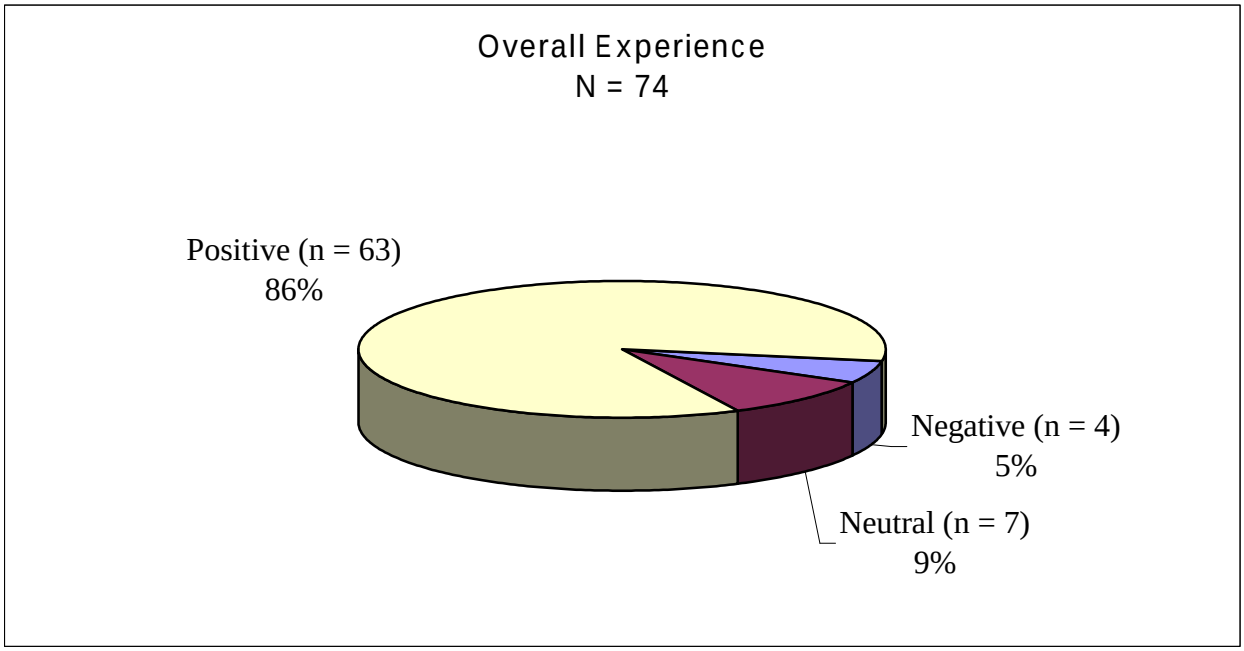
Part I Survey Results

Question #1: *What is your role at the CSA?*



There were 75 respondents to the question on the role of the respondent at the CSA. These 75 respondents included: seventeen (17) senior administrators, 20 program directors, 12 senior care coordinators, 4 senior family partners, 15 care coordinators, and 7 family partners.

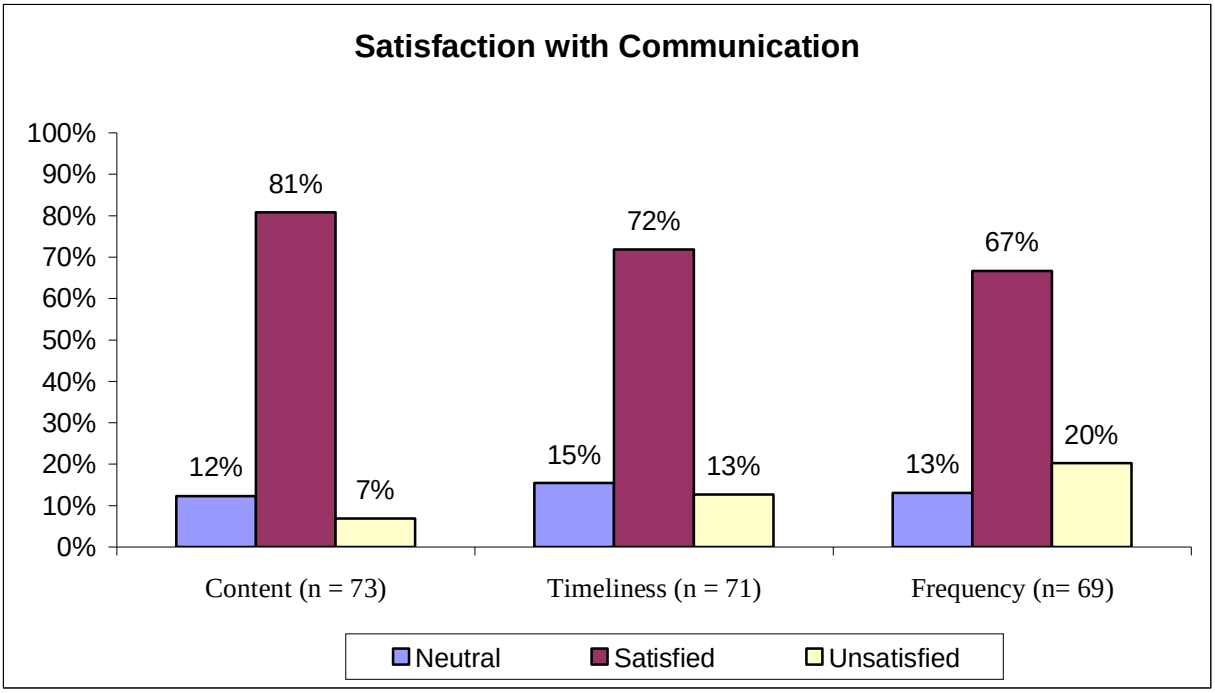
Question #2: *How would you rate your experience working with the MassHealth Managed Care Entities (MCEs) on the implementation of Intensive Care Coordination (ICC) and Family Support and Training (FS&T)?*



The overwhelming majority (85%) of the 74 respondents to this question indicated that their overall experience working with the Managed Care Entities on the implementation of ICC and FS&T has been positive. Nine individuals elaborated on their overall experience with the MCEs in the comments section of this survey question. There were 7 responses that indicated great satisfaction with MCE "customer service" describing the staff of the MCEs as, "responsive", "accommodating", "supportive", and "helpful".

While there was satisfaction with experiences with MCE personnel, there were several comments suggesting dissatisfaction with the policies and procedures surrounding the implementation. One respondent summarized this by writing, "The staff I've worked with have been highly professional and responsive. Some of the policies have been difficult to work with." Additionally there were three responses that suggested that the process has not felt, "like a partnership" and that more opportunities to provide feedback on their experience(s) would lead to greater satisfaction.

Question #3: *Rate your experience/satisfaction with the following communication processes:*
a) Content of communication
b) Timeliness of communication
c) Frequency of communication

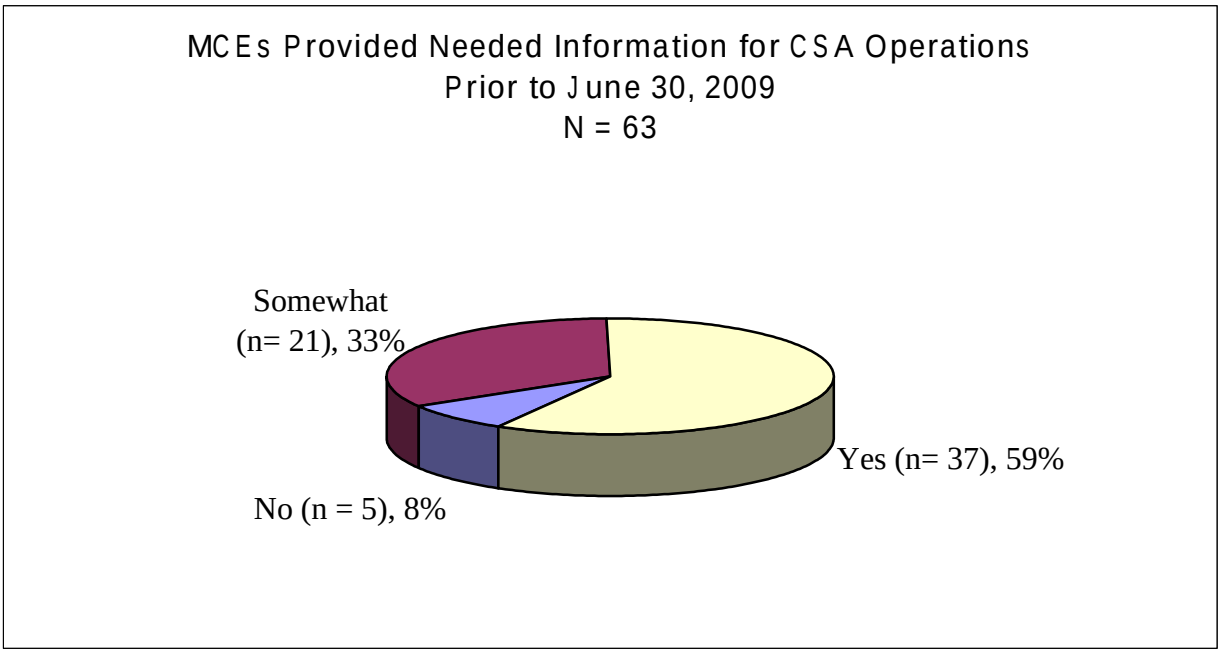


The majority of respondents to this three part question indicated they were satisfied with the content (81%), timeliness (72%), and frequency (67%) of communication.

Those who indicated dissatisfaction were prompted to offer suggestions on strategies to improve communication in the areas of content, timeliness, and frequency. With regard to the content of communication, three respondents indicated that having, "everyone on the same page" would assist them as they sometimes received conflicting information or information that changed quickly from one day to the next. Two respondents suggested they would like more advance notice about required meetings or trainings.

The largest number of respondent comments (10), were related to wanting a more streamlined and efficient process for receiving communication from the MCEs. Respondents noted that the amount of emails and other communications has been overwhelming at times and had made keeping track of important changes difficult to manage.

Question #4: *Did the MCEs provide needed information to ensure that you were prepared to begin CSA operations on June 30th?*

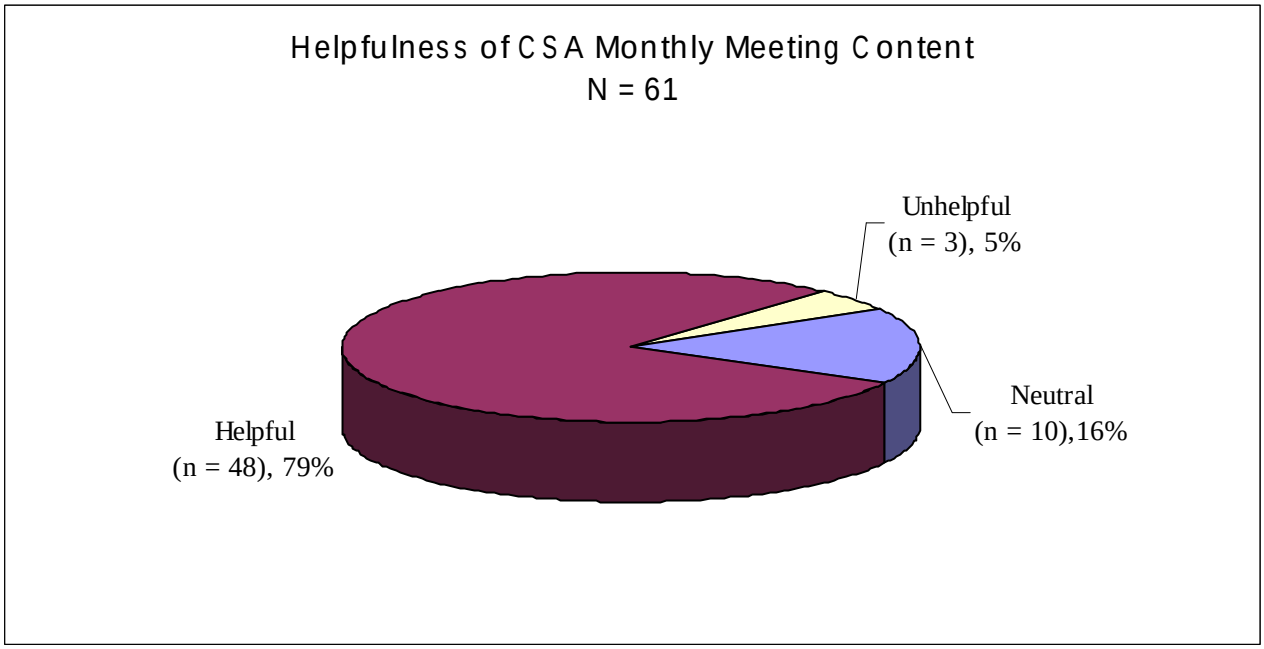


Of the 63 respondents to this question 59% (n = 37) indicated that they did have the information required to begin CSA operations on June 30th with another 33% (n = 21) responding "somewhat" and 8% (n = 5) reporting that they did not have needed information.

Those who responded as "somewhat" or "no" were prompted to detail what additional information would have been helpful. Four respondents indicated the need for more training and information prior to June 30 in areas such as MCE specific authorization procedures and the Wraparound process. There was acknowledgement and understanding however by several respondents that everyone including the MCEs were operating under tight timelines that left everyone with many "unanswered questions" and because ICC and FS&T were new services no one, "really knew what to expect."

Question #5: *How helpful do you find the content of the CSA monthly statewide meetings so far? What you have found to be particularly helpful or unhelpful about the content, format or process of the CSA statewide meeting.*

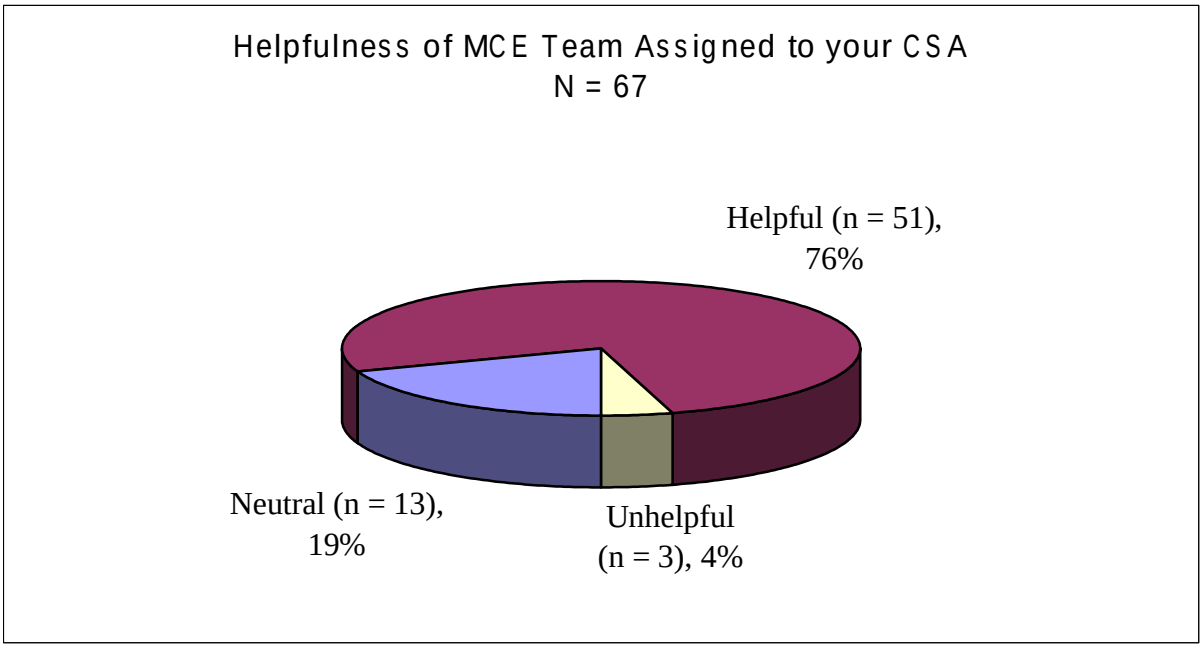
Question #6: *What suggestions do you have for future CSA statewide meetings?*



The vast majority of respondents (79%) indicated that the content of the CSA statewide meeting is helpful. In particular respondents reported particularly liking those meetings where time was devoted to regional break-out sessions for providers to discuss resources, share best practices, and problem solve.

There were many suggestions about how the meeting could be restructured and improved to be more beneficial to meeting attendees. Three respondents suggested they would like more opportunities for question and answer sessions with the MCEs and the chance to offer feedback on MCE policies and procedures. Illustrative of this were comments like, "The agenda is tightly controlled….preventing appropriate questions from being asked" and "So far, these meetings have felt overly focused on transferring info from MCEs to CSAs…".

Question #7: *How would you describe the assistance received from the MCE team assigned to your CSA?*



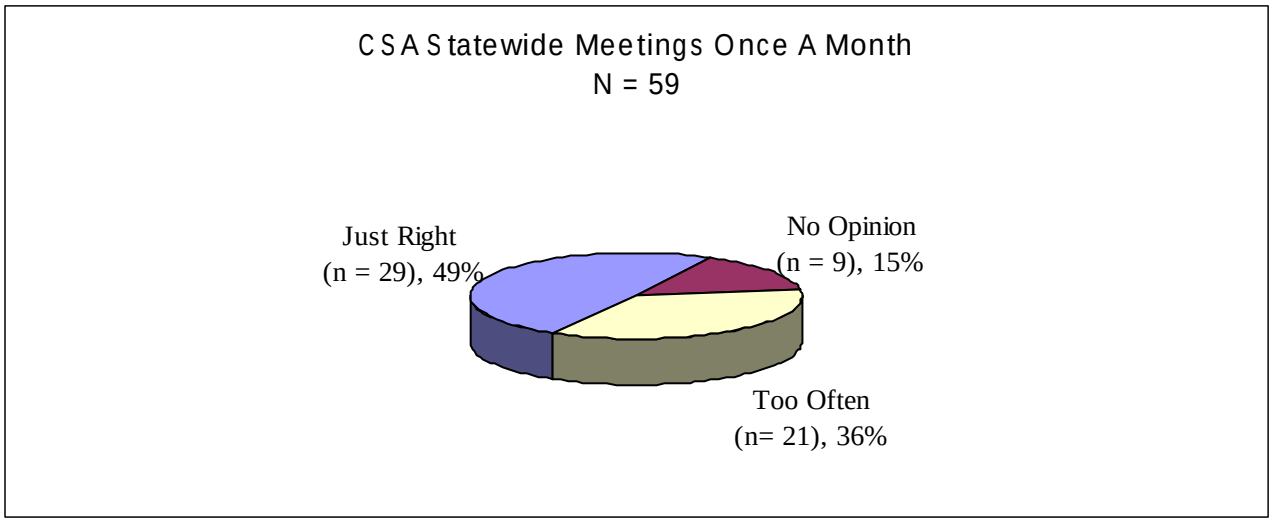
Comments related to this question described the MCE team as offering good customer service to CSA providers, describing the teams as, "helpful", "supportive", and "responsive". The establishment of personal relationships between the CSA and MCE staff was reported as particular helpful as summarized by one respondent, "…having the personal contacts makes it feel more collaborative."

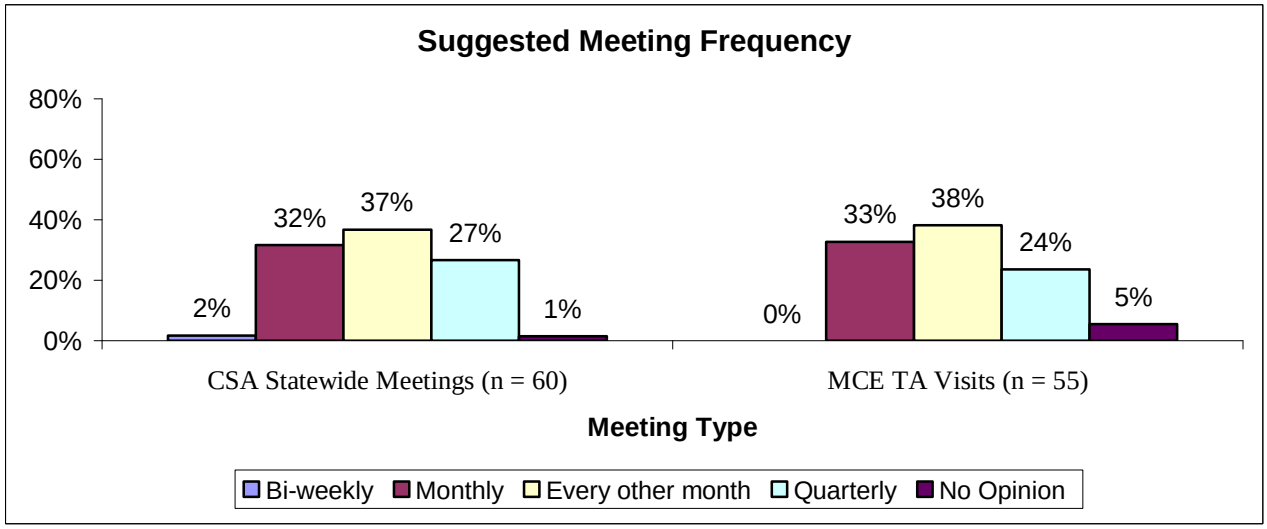
There were five comments indicating that while the team is helpful the meetings can feel overly focused on passing down information from the MCEs as summarized by this comment, "….they have their own agenda and it is not necessarily the same as our agenda." There were also two comments indicating that the weekly calls and reports were burdensome. One additional recommendation was, "…to have the MCE representatives that come out monthly be trained in the (authorization) process…."

Question #8: *Holding CSA statewide meetings once a month is…?*

Question #9: *What scheduling frequency would you recommend going forward for:*

a) statewide meetings
b) on-site visits with MCE team





The majority of respondents endorsed wanting meetings less than monthly. Sixty-four percent (n= 38) of respondents to the question on meeting frequency indicated they wanted CSA statewide meetings less than monthly (i.e. either every other month or quarterly) while 49% (n= 29) of the respondents to question number eight indicated that a monthly statewide meeting was "just right". The majority of comments related to meeting frequency from respondents did however endorse wanting to change to a less frequent CSA statewide meeting structure illustrated by comments like: "Meetings could be shorter and less often"; "Monthly meetings are a burden," and "Monthly seems too frequent."

Part I Results Summary

- The majority of respondents indicated their experience working with the MCEs on the implementation of ICC and FS&T was quite positive and described the efforts of the MCEs as, “helpful”, “supportive”, and “responsive”.

- The establishment of personal relationships through the technical assistance visits at each CSA was described as particularly helpful.

- Providers indicated that the frequency of emails and other communications from the MCEs has been challenging to absorb and integrate into their business and clinical operations.

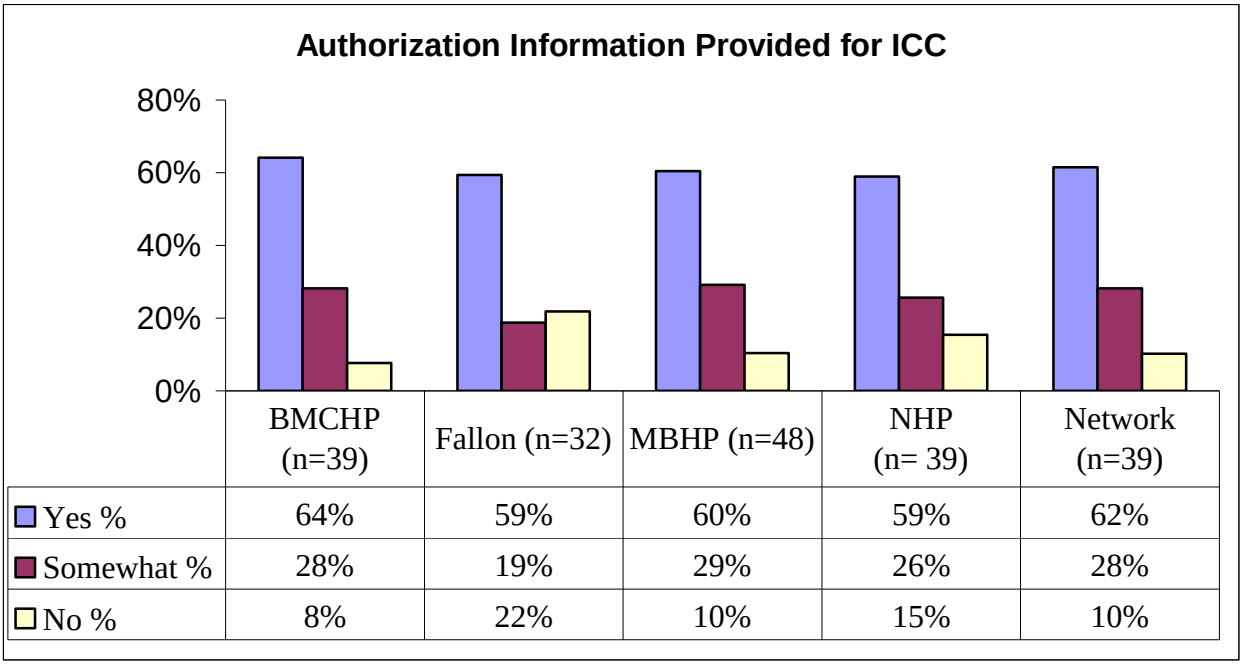
- Providers identified that increased opportunities for reciprocal exchanges of information during meetings would enhance collaboration between the providers and the MCEs.

- Providers indicated they appreciate opportunities to meet with their colleagues to share best practices and problem solve and expressed wanting more time in existing meetings to do this.

- Reducing both CSA statewide and MCE Technical Assistance meetings to a less than monthly schedule was endorsed by a majority of respondents.

Part II Survey Results

Question #1: *Was your organization provided with all the information needed to complete the authorization process for members enrolled in ICC for each of the following MCEs?:*

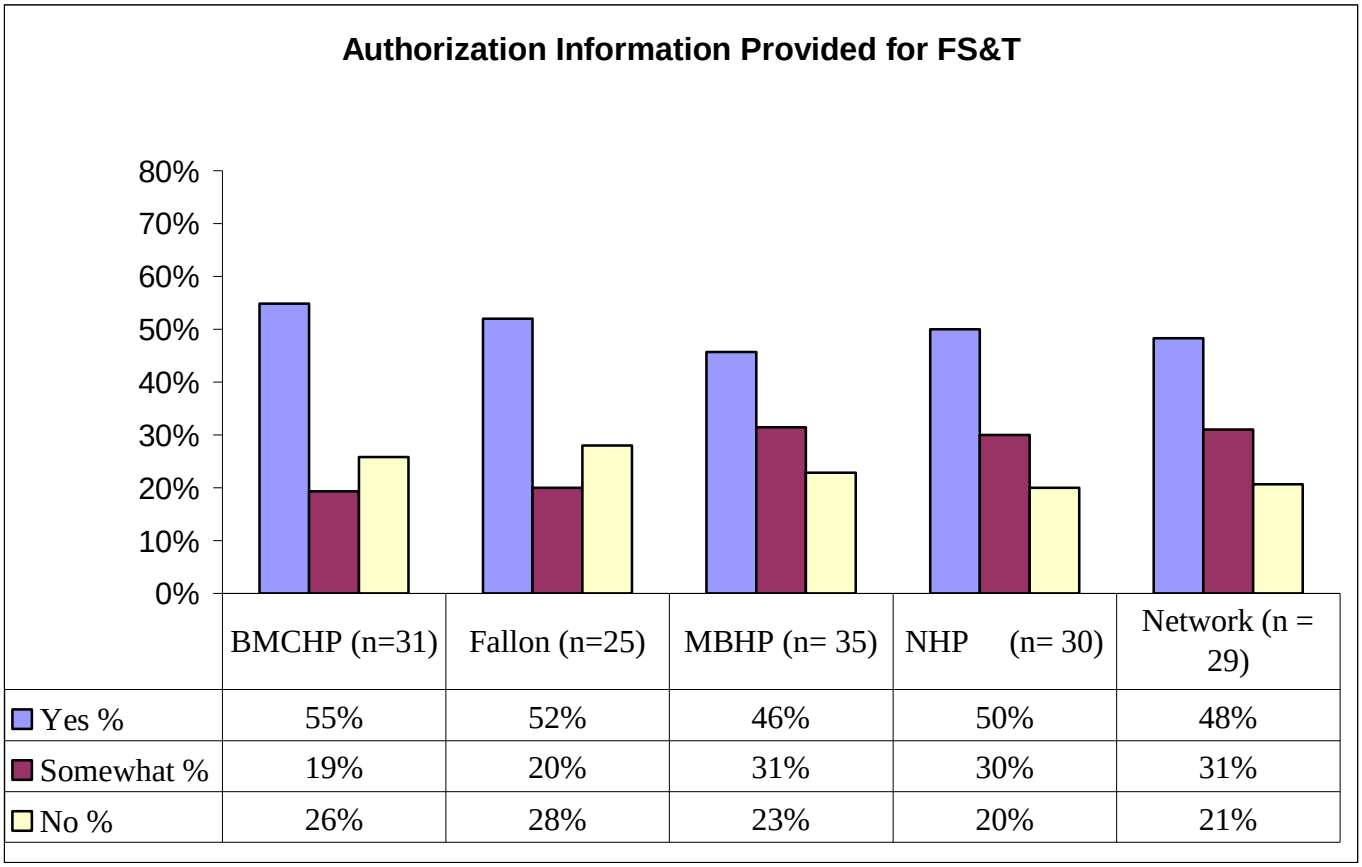


	BMCHP (n=39)	Fallon (n=32)	MBHP (n=48)	NHP (n= 39)	Network (n=39)
Yes %	64%	59%	60%	59%	62%
Somewhat %	28%	19%	29%	26%	28%
No %	8%	22%	10%	15%	10%

The majority of respondents indicated they had the information they needed to complete the authorization process for members enrolled in ICC for each of the five MCEs with a range from 59% for Fallon and NHP to 64% for BMCHP. The highest no response was for Fallon at 22% however it is unclear if this is simply related to the fact that Fallon members are concentrated in central Massachusetts and respondents in other regions of the state simply have not had exposure to Fallon's authorization processes and procedures or did not review materials sent to them because it was not relevant for the population of youth they serve.

There were four comments related to providers describing not being provided enough advance notice about the MCEs authorization processes and procedures. One respondent summarized this by saying, "…I thought the authorization/billing procedures came very late (way too close to the launch date) which made it very difficult for the organization to do its proper planning internally for how we would handle some of the financial infrastructure issues." Additional information that respondents indicated would have been helpful was: a list of the clinical review questions asked by BMCHP (1 respondent) and Network Health (1 respondent), additional contact information at the health plans (1 respondent), and health plan specific training on what is needed for authorizations (1 respondent).

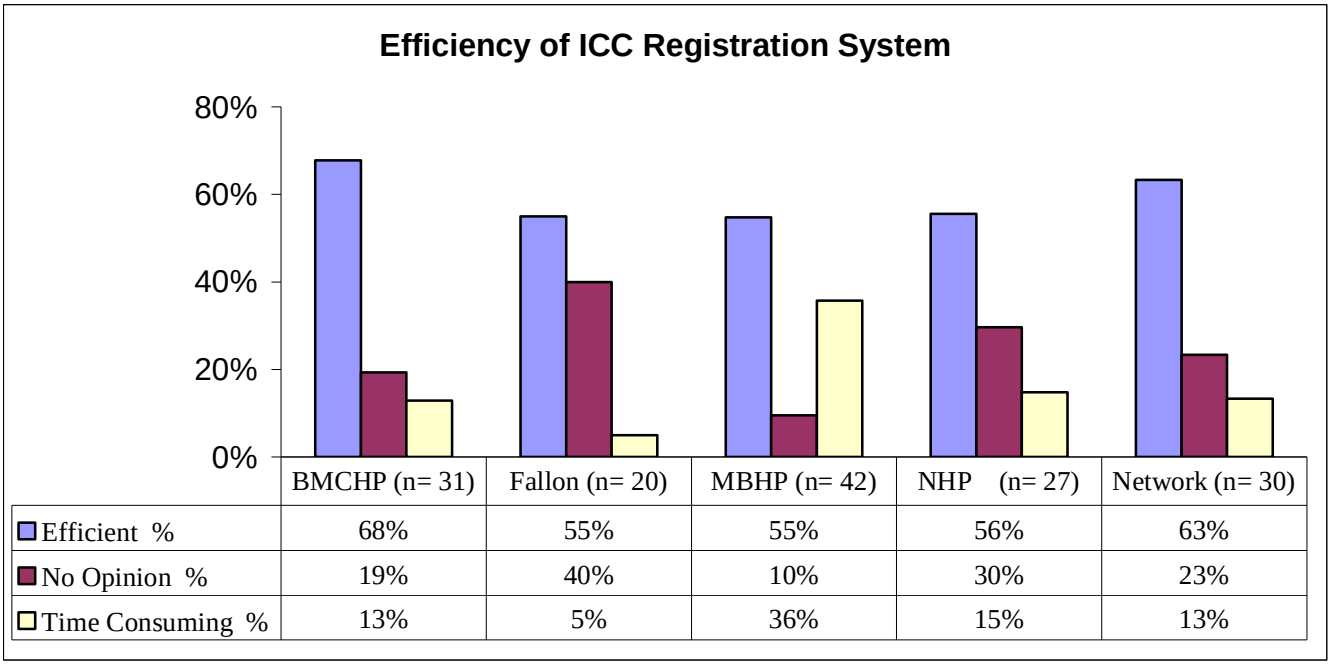
Question #2: *Was your organization provided with all the information needed to complete the authorization process for members enrolled in Family Support and Training (FS&T) (independent of ICC) for each of the following MCEs:*



	BMCHP (n=31)	Fallon (n=25)	MBHP (n= 35)	NHP (n= 30)	Network (n = 29)
Yes %	55%	52%	46%	50%	48%
Somewhat %	19%	20%	31%	30%	31%
No %	26%	28%	23%	20%	21%

The total number of respondents by health plan was lower for this question ranging from 29 for Network Health to 35 for MBHP. Many respondents either skipped this question or responded with "not applicable." While the majority of respondents indicated a "yes", a significant percentage indicated they did not receive the information or only had some of the needed information.

Question #3: *How would you rate the efficiency of the ICC registration (i.e. the system used by the MCEs to obtain the initial authorization for ICC) process for members enrolled with the following MCEs?:*

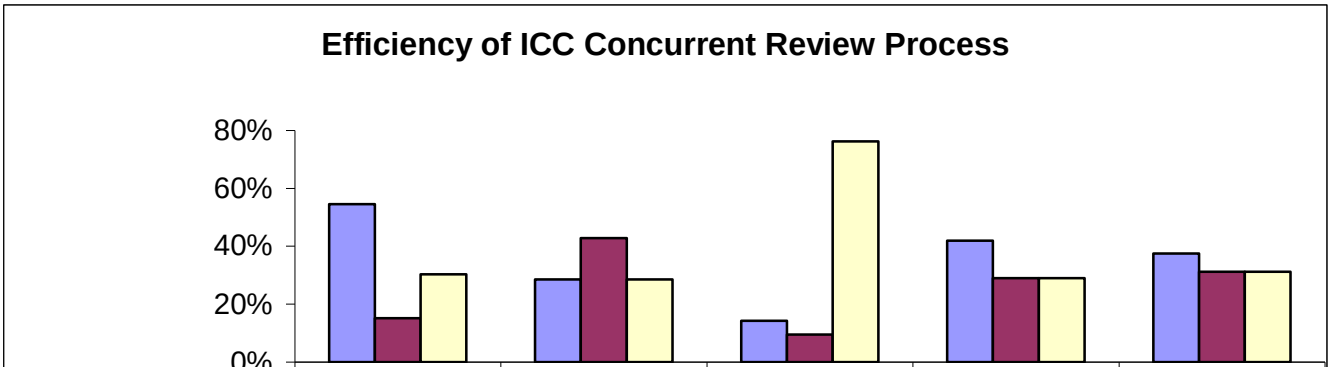


	BMCHP (n= 31)	Fallon (n= 20)	MBHP (n= 42)	NHP (n= 27)	Network (n= 30)
Efficient %	68%	55%	55%	56%	63%
No Opinion %	19%	40%	10%	30%	23%
Time Consuming %	13%	5%	36%	15%	13%

The registration process, the system used by the MCOs to obtain the initial authorization for ICC, is completed by either a phone call with a plan representative (BMCHP, Fallon, NHP) or completion of a registration form that is faxed to the health plan (Network Health). Initial authorization for MBHP members is obtained using a web-based system authorization system.

BMCHP's registration system had the highest efficiency rating at 68% followed by Network Health at 63% with NHP at 56% and Fallon, and MBHP at 55%. A relatively small percentage of respondents indicated that the registration process was time consuming, however the system used by MBHP was rated as more time consuming than those used by the BMCHP, Fallon, NHP, and Network Health.

Question #4: *How would you rate the efficiency of the ICC concurrent review (i.e. the system used by the MCEs to obtain continued service authorization beyond the initial authorization period) process for members enrolled with the following MCEs?:*



	BMCHP (n= 33)	Fallon (n= 21)	MBHP (n= 42)	NHP (n= 31)	Network (n= 32)
Efficient %	55%	29%	14%	42%	38%
No Opinion %	15%	43%	10%	29%	31%
Time Consuming %	30%	29%	76%	29%	31%

BMCHP, Fallon, NHP, and Network Health require that providers obtain continued service authorization for ICC beyond the initial authorization period, a process termed concurrent review, via a telephonic review between a clinician at the health plan and a care coordinator or supervisor at the CSA. MBHP uses a web-based authorization system.

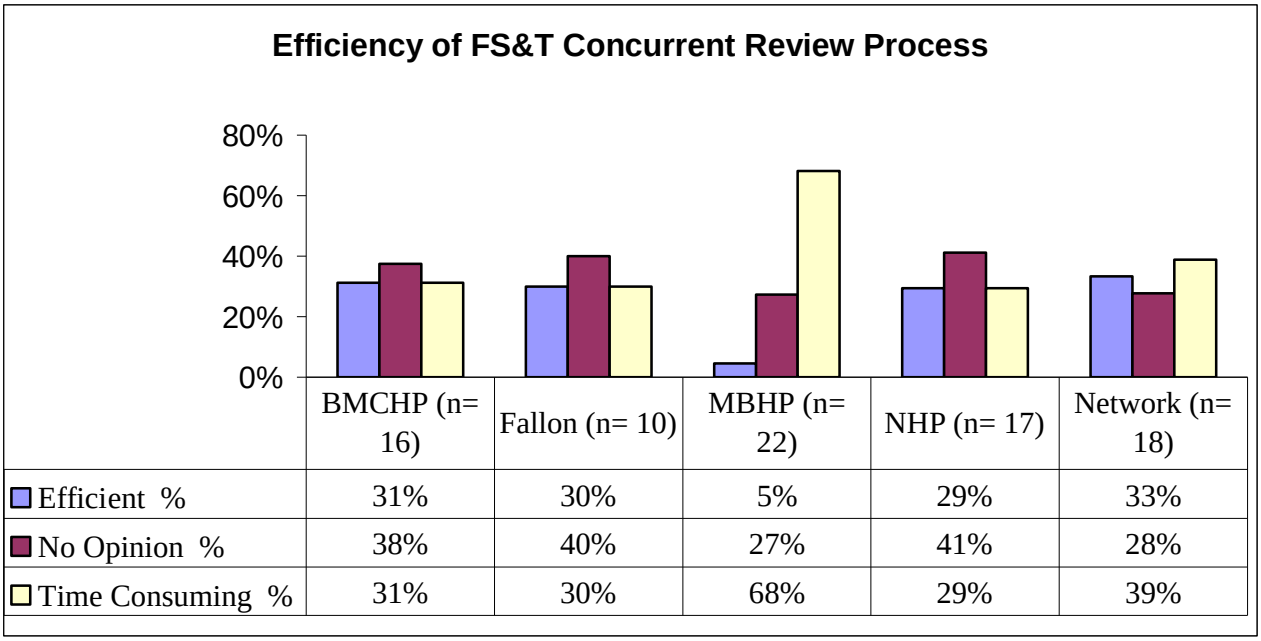
The concurrent review process used by BMCHP was rated as the most efficient at 55%. There were two comments describing the experience with BMCHP which were: "Reports of people using BMC are very positive due to the ease in which an authorization can be obtained. Appointments are scheduled with the Intensive Case Management (ICM) for the concurrent reviews and care coordinator can get the autho [sic] and move on to working with families"; and "The BMC process for authorization has been very easy to follow and our ICM as well as other contacts have been very helpful and efficient."

Several providers commented on the ease of interface between the Managed Care Organizations (MCO) and those responsible for obtaining the authorization at the CSA. Comments reflective of this included: "BMCHP, Fallon, NHP and Network Health have all been great. The process is straightforward, and worked pretty well right from the start"; "….(Some) MCE's allow us to fax documents which is a much more efficient use of our time."

The vast majority of respondents (76%) utilizing the web-based system used by MBHP to obtain authorizations, evaluated the process as "time consuming". Several respondents commented about problems with the web-based system suggesting that technology "glitches" contributed to the length of time it takes to complete a concurrent review. One respondent summarized this by saying, "With MBHP it has been challenging to work with a computer

system that does not have all the technical difficulties worked out." One responded suggested that, "It would be much easier if we could fax the safety plan and care plan and/or do a telephonic review." There was acknowledgement by at least one respondent that there are positive aspects to MBHP's web-based system which was summarized as, "What is nice about the computer system is having the information easily accessed online and the possibility of the information being saved and making edits for the second concurrent. The 30 days window is also very helpful considering the amount of information that must be put in for the first concurrent." This comment suggests that for subsequent concurrent reviews for a youth the time frame could be shorter given that the information from the previous review has already been entered and only requires updates as opposed to all new information.

Question #5: *How would you rate the efficiency of the FS&T concurrent review (i.e. the system used by the MCEs to obtain continued service authorization beyond the initial authorization period) process for members enrolled with the following MCEs?:*

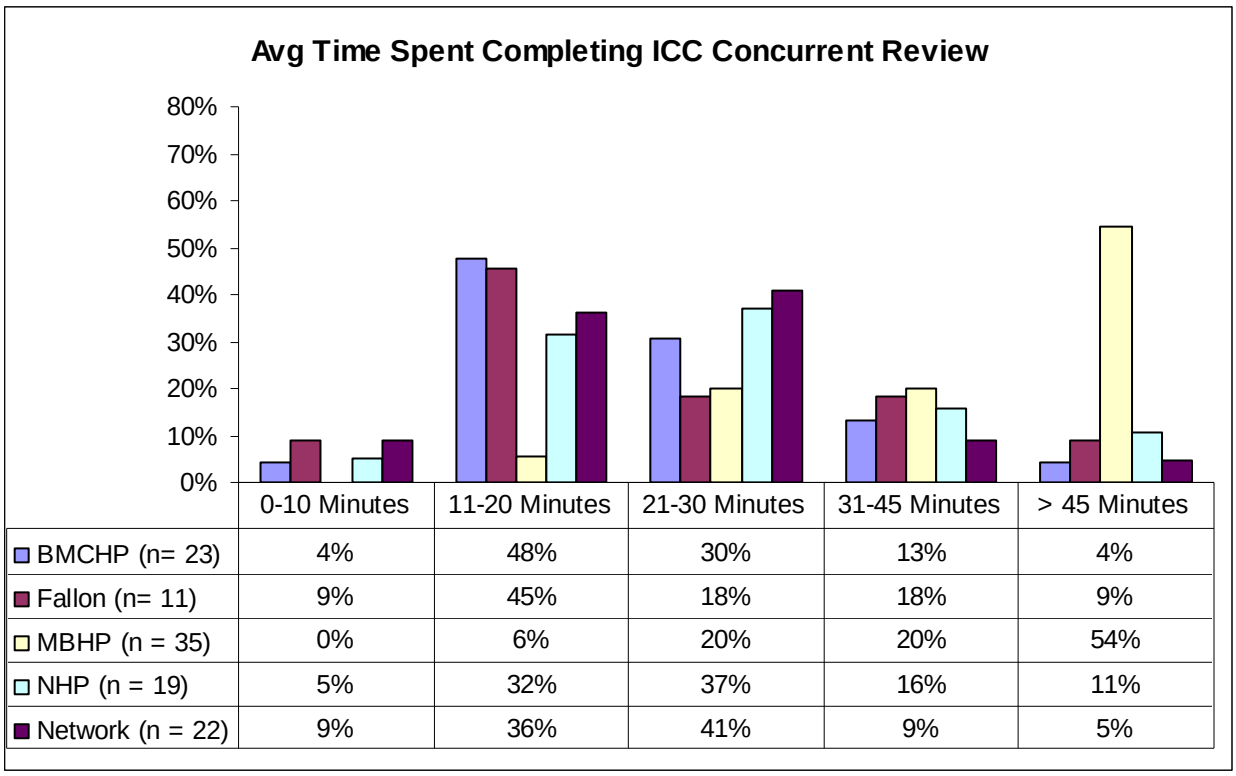


	BMCHP (n= 16)	Fallon (n= 10)	MBHP (n= 22)	NHP (n= 17)	Network (n= 18)
Efficient %	31%	30%	5%	29%	33%
No Opinion %	38%	40%	27%	41%	28%
Time Consuming %	31%	30%	68%	29%	39%

BMCHP, Fallon, NHP, and Network Health require that providers obtain continued service authorization for FS&T beyond the initial authorization period via a telephonic review between a clinician at the health plan and a care coordinator or supervisor at the CSA. As described earlier, MBHP requires that providers utilize a web-based authorization system to obtain authorization for ICC and FS&T.

The number of respondents to this question was low compared to that for the question related to ICC. This is likely due to the fact that for youth with ICC and FS&T, the authorization for FS&T is obtained as part of the ICC concurrent review, therefore many respondents did not have experience obtaining an FS&T authorization independent of ICC and either skipped this question or responded as having, “no opinion”. Similar to the question on ICC however, those respondents utilizing the web-based system to obtain the authorization for FS&T rated it is a more time consuming process than that of the MCEs for the reasons described above.

Question #6: *How long on average, does it take you to complete a single ICC concurrent review (i.e. the system used by the MCEs to obtain continued service authorization beyond the initial authorization period):*

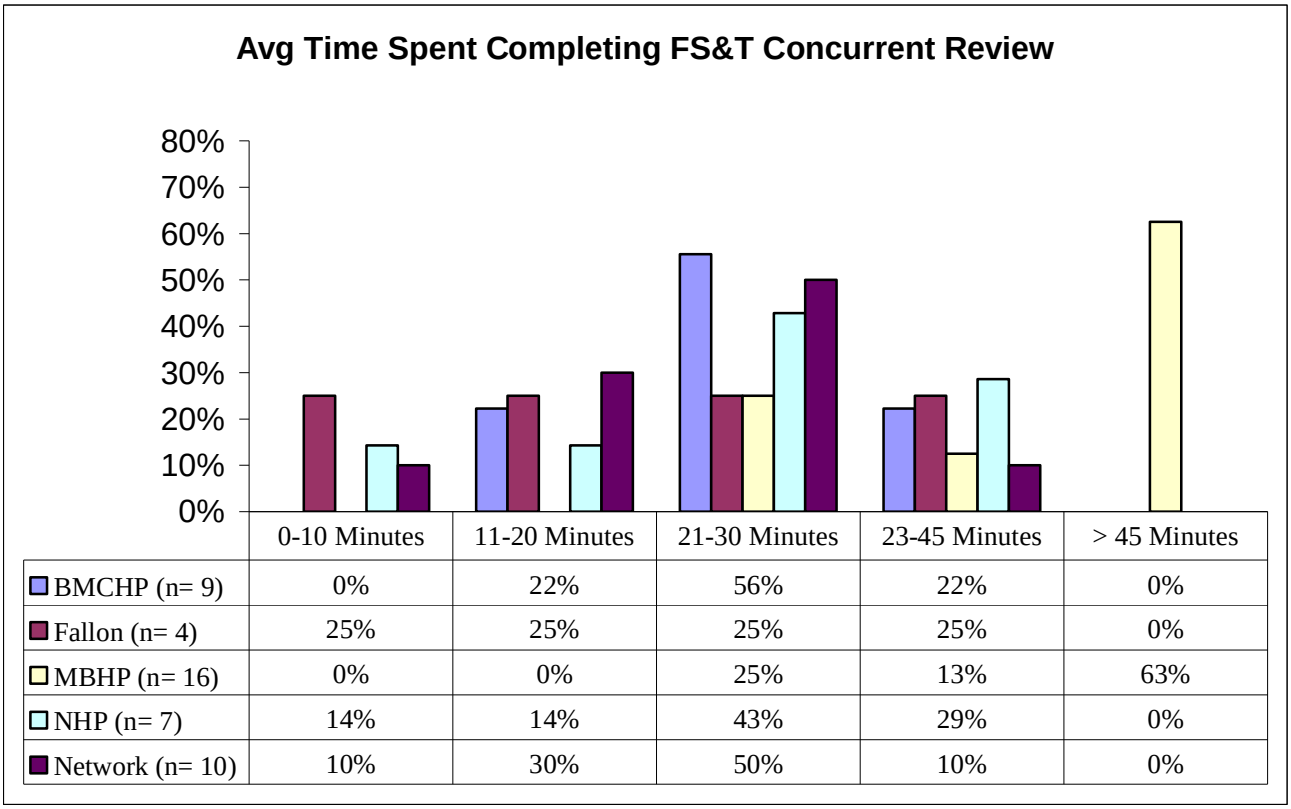


	0-10 Minutes	11-20 Minutes	21-30 Minutes	31-45 Minutes	> 45 Minutes
BMCHP (n= 23)	4%	48%	30%	13%	4%
Fallon (n= 11)	9%	45%	18%	18%	9%
MBHP (n = 35)	0%	6%	20%	20%	54%
NHP (n = 19)	5%	32%	37%	16%	11%
Network (n = 22)	9%	36%	41%	9%	5%

The majority of respondents indicated that it takes 30 minutes or less to complete a single ICC concurrent review with the BMCHP, Fallon, NHP, and Network Health. The MCOs all conduct concurrent reviews via phone between a clinician at the plan and the care coordinator or supervisor at the CSA.

For respondents using MBHP's web-based authorization system 20% indicated it takes between 31-45 minutes with another 54% reporting that the average time to complete an ICC concurrent review is longer than 45 minutes. Technology issues with the web-based authorization system were identified by many respondents as the reason why obtaining authorization was particularly time consuming. Other respondents suggested that the review process was time consuming because the user interface was not intuitive or "user friendly". Comments reflective of this included: "The first concurrent authorization is cumbersome. Sometimes drop-down menus appear but not at other times….For some of my staff, finding how to use the "Manage Consent" function was a problem."; and "…the concurrent review is extremely long/time consuming and repetitive. We are asked to re-document information that we have already documented, some of which is on mandated forms." There were several comments that the length of time spent completing concurrent reviews, "keeps us from doing direct work with the families" as well as that the time spent completing concurrent reviews is, "…not billable in terms of productivity."

Question #7: *How long, on average, does it take you to complete a single FS&T concurrent review with the following MCEs?:*



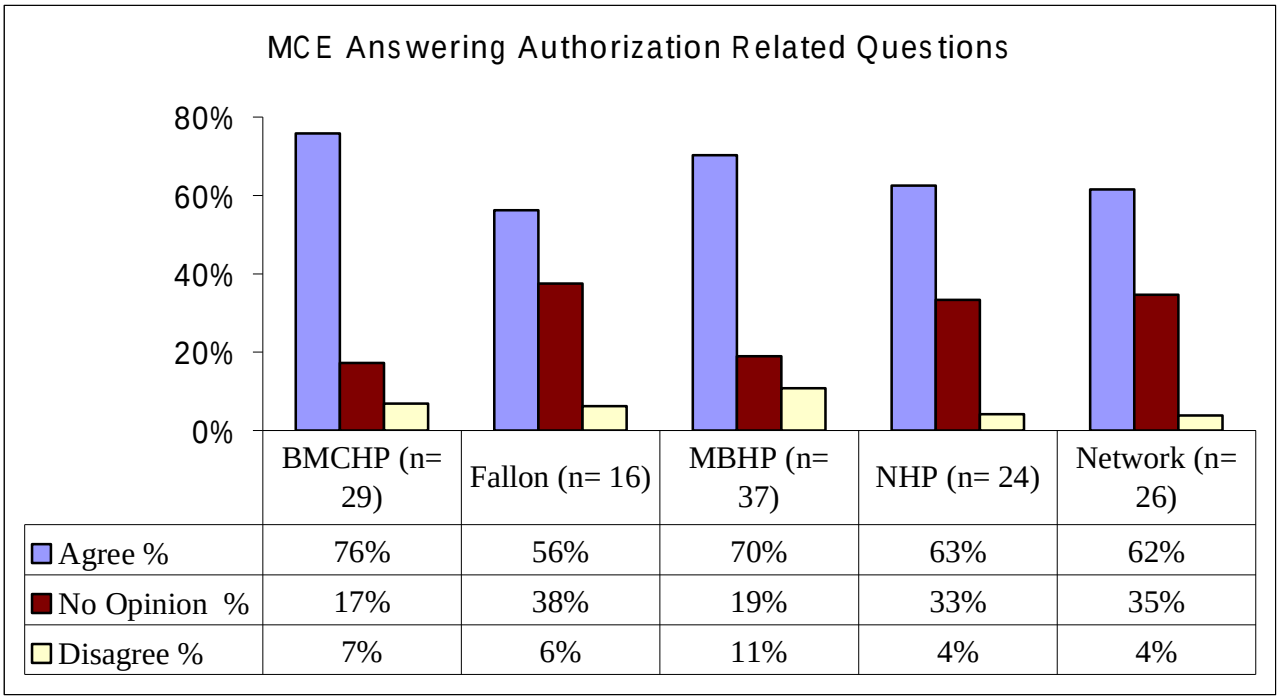
	0-10 Minutes	11-20 Minutes	21-30 Minutes	23-45 Minutes	> 45 Minutes
BMCHP (n= 9)	0%	22%	56%	22%	0%
Fallon (n= 4)	25%	25%	25%	25%	0%
MBHP (n= 16)	0%	0%	25%	13%	63%
NHP (n= 7)	14%	14%	43%	29%	0%
Network (n= 10)	10%	30%	50%	10%	0%

The process used by the BMCHP, Fallon, NHP, and Network Health to obtain continued authorization for FS&T beyond the initial 28 days is completed via telephonic review between a clinician at the health plan and a care coordinator or supervisor at the CSA. MBHP uses a web-based authorization system.

The number of respondents to this question was low compared to that for the question related to ICC, this is likely due to the fact that for youth with ICC and FS&T, the authorization for FS&T is obtained as part of the ICC concurrent review, therefore many respondents did not have experience obtaining an FS&T authorization independent of ICC and either skipped this question or responded as having, “no opinion”. There was a similar response pattern to that of the question about ICC concurrent review, with the majority of respondents indicating that it takes 30 minutes or less to complete a single ICC concurrent review with BMCHP, Fallon/Beacon, NHP/Beacon, and Network Health.

For respondents using the web-based authorization system 13% indicated it takes between 31-45 minutes with another 63% reporting that the average time to complete an ICC concurrent review is longer than 45 minutes.

Question #8: *Please rate your agreement with the following statement: The MCE clinical review staff from the following MCEs have been able to answer my CSA related authorization questions(s) and/or direct me to a plan representative who could answer my questions(s).*

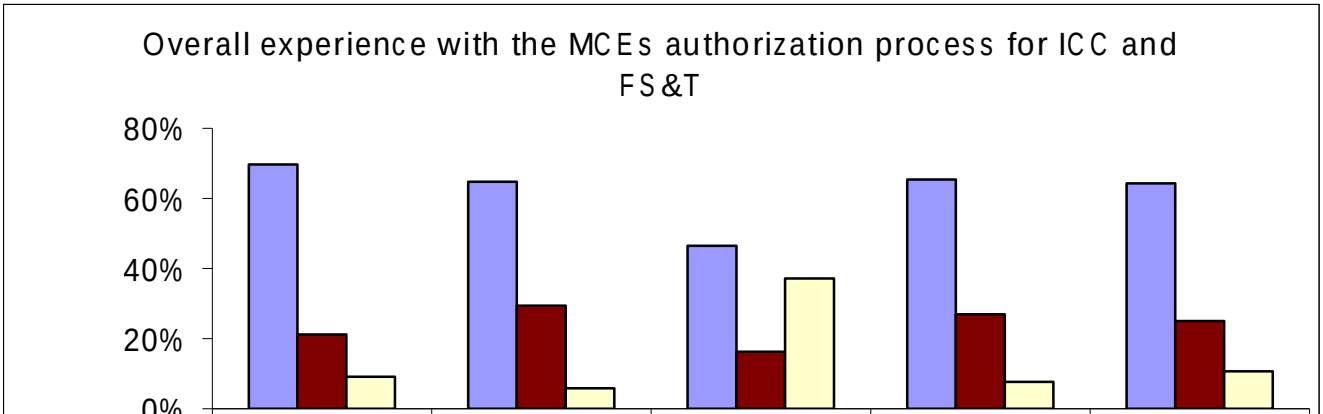


	BMCHP (n= 29)	Fallon (n= 16)	MBHP (n= 37)	NHP (n= 24)	Network (n= 26)
Agree %	76%	56%	70%	63%	62%
No Opinion %	17%	38%	19%	33%	35%
Disagree %	7%	6%	11%	4%	4%

The majority of respondents indicated that the MCEs were able to answer their authorization related questions or direct them to someone who could answer their questions. This response pattern is consistent with responses in part I of the survey that described the MCEs staff as "responsive", "accommodating", "supportive", and "helpful".

Specifically respondents indicated that ICM staff persons from the health plans were particularly knowledgeable and helpful. Comments reflective of this included: "The ICM's are extremely supportive of the staff calling for authorizations and asking questions" ; " Our ICM through MBHP has been amazingly helpful and efficient." and "….our ICM (from BMC) as well as other contacts have been very helpful and efficient."

Question #9: *How would you rate your overall experience with the following MCEs authorization process for ICC and FS&T?*



	BMCHP (n= 33)	Fallon (n= 17)	MBHP (n= 43)	NHP (n= 26)	Network (n= 28)
Positive %	70%	65%	47%	65%	64%
No Opinion %	21%	29%	16%	27%	25%
Negative %	9%	6%	37%	8%	11%

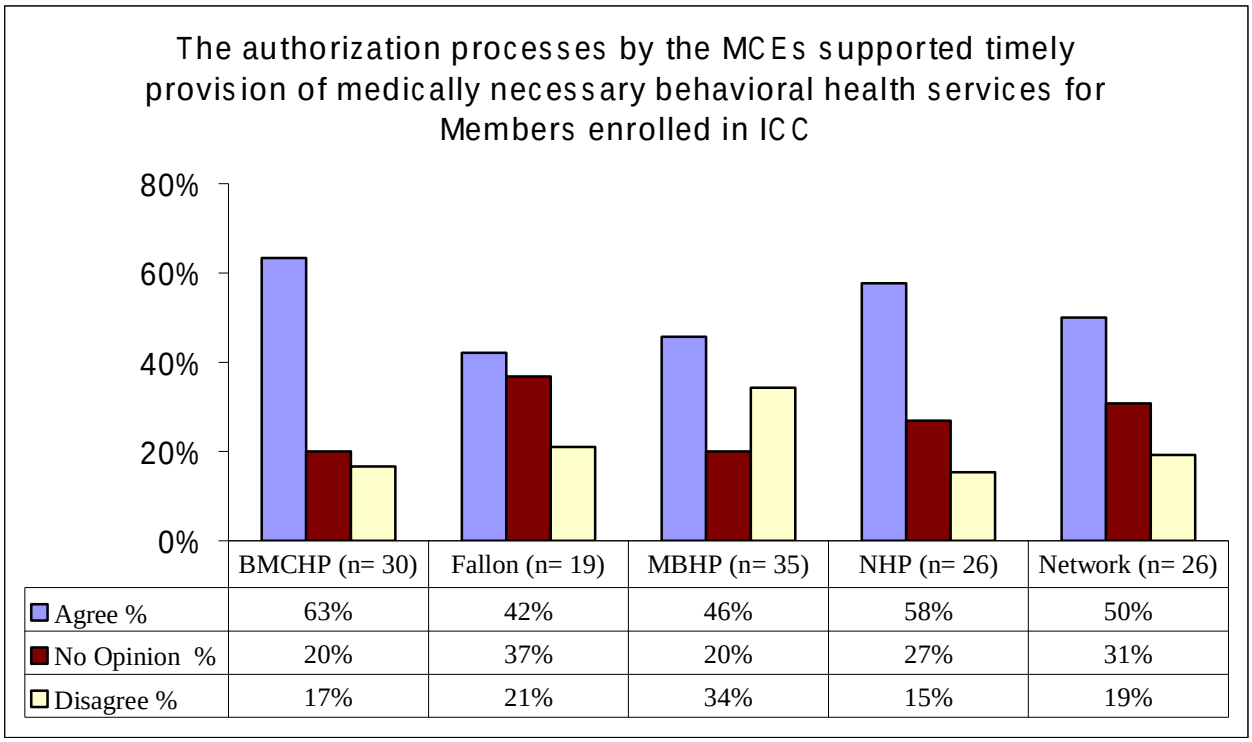
Responses indicate that the overall experience with the MCEs authorization process was positive with a range from 70% for BMCHP to 47% for MBHP. While overall the experience with the authorization processes for each of the MCEs was rated as positive by a majority of respondents, there were comments and concerns in two areas that were common across health plans.

The first area was related to the 28 day time frame for the initial authorization. The decision to have a 28 day initial authorization period was made in an attempt to reinforce the practice model that specifies a 28 day time frame for completion of the first care plan team meeting. Providers indicated however that the coupling of the initial authorization period with 28 day time frame for completion of the first CPT did not allow for enough flexibility. Comments included: "Right now MBHP gives us a 90 day autho which allows us some flexibility when trying to get the family to call us back, engage, etc….However, the other MCEs [sic] give us a 28 day auth which means if the family does not engage right away we as providers then need to call back, notify the MCE [sic] and get new dates—this is a cumbersome process for the ICC"; and "Some are making it difficult to get authorizations from time of initial contact without counting the 28 days from there. I understood from the last CSA meeting that there was going to be flexibility with that and it has not proven so."

The other issue common across MCEs and generating considerable feedback from survey respondents was the challenges in having to navigate five different health plans with different authorization procedures and processes. While considerable efforts have been made by the MCEs to collaborate and establish similar authorization parameters for services, differences remain. Many respondents expressed a desire for increased uniformity across MCEs as reflected by these comments: "Much more consistency (amongst plans) would have made start up of the CSAs far more [sic] smoother"; "It would be helpful to have the MCEs all follow the same process";

"Initial authorization process was not clear as each MCE was different" and "I don't believe the MCEs or CSA knew how labor intensive this process was going to be, especially since each MCE has its own procedures and expectations." Respondents went on to express that understanding how to interface with different MCEs with varying procedures contributed to confusion. One respondent summarized this by writing, "It was all very confusing I had to call several times to get it correct for each of the MCEs".

Question #10: *Please rate your agreement with the following statement: The authorization processes and procedures used by the following MCEs supported timely provision of medically necessary behavioral health services for Members enrolled in ICC.*



	BMCHP (n= 30)	Fallon (n= 19)	MBHP (n= 35)	NHP (n= 26)	Network (n= 26)
Agree %	63%	42%	46%	58%	50%
No Opinion %	20%	37%	20%	27%	31%
Disagree %	17%	21%	34%	15%	19%

Agreement with this statement ranged from 63% for BMCHP to 42% for Fallon. There were a high number of respondents who indicated they had "no opinion" about this particular question with a high of 37% for Fallon to 20% for BMCHP and MBHP.

There were no comments on the survey indicating that Members in need of medically necessary behavioral health services were denied services by any of the MCEs nor were there comments suggesting that the authorization processes used by the MCEs had impeded care for Members. While the intent of this question was to understand if the MCE's authorization processes led to delays in Members receiving care, in answering this question, respondents may have been commenting on the efficiency or timeliness of the authorization procedures for the provider organizations.

Part II Results Summary

- Respondents indicated that ICM staff persons from the health plans were particularly knowledgeable and helpful.

- The data suggested that more information on how to obtain authorization of FS&T independent of ICC could be an area for further education and information dissemination by the MCEs.

- Across the five MCEs providers reported that clinical review staff or other plan representatives were able to answer authorization related questions.

- There were considerable concerns expressed related to the technology "glitches" and the amount of time providers reported spending obtaining authorizations via MBHP's web-based authorization system.

- Navigating five MCEs with differing authorization practices and procedures was reportedly challenging for providers who are at the same time learning a new practice model and service delivery process.

- BMCHP, Fallon, NHP, and Network Health all have an initial authorization period for ICC and FS&T of 28 days. The decision to have a 28 day initial authorization period was made in an attempt to reinforce the practice model that specifies a 28 day time frame for completion of the first care plan team meeting. Providers indicated that engaging families, conducting a comprehensive home-based assessment, convening the first care plan team meeting and drafting the first individual care plan in that 28 day initial authorization period is challenging and creates administrative burden as the provider(s) must call sometimes multiple times to request a date extension from the health plan.

- The highest overall satisfaction was with those health plans that conducted authorization reviews via phone between a clinician at the plan and the care coordinator or supervisor at the CSA.

Conclusion and Recommendations

Part I: Communication Strategies

Implementing a new statewide initiative such as CBHI across multiple providers and payers always presents communication challenges. An enormous amount of critical information must be shared in a variety of areas such as authorization procedures, operational policies, clinical criteria, training information, meeting notices, data requests, etc. in order to ensure that providers and the MCEs have the information they both need to perform their business operations and serve youth and families. Due to the vast amount of information connected to this effort, multiple strategies have been employed to ensure rapid relay of information including email, phone calls, written materials, web-postings, and face-to-face meetings. As noted by survey respondents, to date information flow has felt one-sided and has heavily focused on transfer of information from the MCEs. They indicated that they would like more opportunities to offer feedback to the MCEs and to network with other CSA providers. That being said, the majority of survey respondents indicated that despite feeling "overwhelmed" by the amount and frequency of communications, the MCEs efforts were consistently described as "helpful", "supportive", and "responsive". The establishment of personal relationships through the technical assistance visits that occur between senior staff at each CSA and representatives from the MCEs was described as particularly helpful.

In response to provider concerns about communication, the MCEs have already begun to take steps to improve communication in the following areas:

- The MCEs have convened a stakeholder group consisting of, a group of providers delivering CBHI services from across the state, representatives from the Association for Behavioral Healthcare, and MassHealth. The purpose of this group is to work collaboratively to identify areas of strength and need in areas such as communication, to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system.

- The MCEs have worked together to send out joint communications whenever possible to reduce redundancy and have agreed to utilize MBHP's website for posting of CSA specific materials.

- More time in recent CSA statewide meetings has been devoted to regional break-out sessions to allow providers more time to network, share best practices, and problem solve.

- Attempts have been made to reduce mass email communication and have critical time-sensitive information be relayed in real-time directly from the MCEs to staff at the CSA.

- The MCEs have asked for feedback directly from the CSA providers regarding the recommended frequency of statewide and other meetings.

MassHealth will continue to work with the MCEs to ensure that communication strategies employed by the MCEs are collaborative, streamlined, coordinated, and efficient. A communication action plan will be requested by MassHealth that addresses the areas of need related to communication and promotes opportunities for providers to exchange ideas and develop "learning communities" to assist providers who are engaged in the effort of delivering children's behavioral health services in a different way.

Part II: Authorization Processes

Across the managed care industry a variety of strategies are used to authorize medically necessary care and monitor and manage health-care utilization—no "gold standard" exists. Managed care entities make decisions about their authorization procedures and utilization strategies based on a multiple factors including but not limited to: number of health plan members, familiarity with the service for the health plan and the provider community, how restrictive the service is for the member (i.e. locked inpatient versus outpatient care), service cost, and use of the service(s) across the health plan membership. Based on the aforementioned factors, health plans employ differing strategies and practices such as prior-authorization requirements, direct clinician to clinician telephonic reviews, retrospective reviews of care, outlier management, and use of innovative technologies such as web-based and interactive voice response systems. The MCEs have standardized authorization practices for CBHI services in many respects. Differences do exist however. Differing authorization practices allow the MCEs to develop processes that are tailored to the particular service, health plan membership, health plan resources, and provider needs for support and assistance. Differing authorization and utilization management practices also allows for identification of promising and best practices that can be promoted across the industry. Survey respondents already identified some practices used by the MCEs that were particularly helpful and efficient including:

- BMCHP has its ICM staff make "appointments" with those individuals at the CSA charged with obtaining ICC service authorizations which respondents identified as particularly efficient.

- Fallon and NHP dedicated specific clinical review staff to the CBHI effort to create a team that become in-house "experts" on CBHI services.

- Network Health conducts a "whole care plan review" where a single integrated plan is used by the health plan to authorize behavioral health services recommended by the care planning team.

- MBHP's web-based system allows for information to be easily accessed online and allows for the possibility of saving information and making edits to make the second authorization review more efficient.

Survey respondents also identified several areas of need related to service authorization practices that MassHealth will work on with the MCEs to address. These areas include:

- The decision to have a 28 day initial authorization period was made in an attempt to reinforce the practice model that specifies a 28 day time frame for completion of the first care plan team meeting. Allowing for a longer initial authorization period, while continuing to reinforce the expectation that the care planning team meet within 28 days, would decrease administrative burden on providers and MCE staff to obtain and approve authorization extensions.

- MBHP's web-based system requires system improvements and additional technical assistance to providers in order to increase the efficiency of this system and reduce administrative burden on providers. MBHP has already taken steps to improve system performance and offer technical assistance to providers including starting user groups, delivering on-site technical assistance from MBHP staff, and upgrading the user interface based on provider feedback. MassHealth will request an action plan from MBHP that seeks to continue to improve the performance of their web-based system.

- Continuing to work with the MCEs to identify areas where they can collaborate and standardize authorization practices to reduce confusion and simplify the authorization process for providers.

Acknowledgement and Next Steps

MassHealth would like to take this opportunity to thank those providers who took time to respond to this survey. Provider feedback is invaluable particularly at this point in the implementation process where early identification of best practices and areas for improvement promotes the long-term success of ICC and FS&T. As part of a continuous quality improvement effort, MassHealth intends to conduct additional surveys in the future on provider experiences related to their ongoing work with the MCEs and the implementation of CBHI services.

Addendum to the Managed Care Entity and Community Service Agency Interface Survey
January 2010

Since the survey was distributed at the end of September 2009, it is important to recognize that in addition to the actions already taken by the Managed Care Entities (MCEs) to respond to provider issues and concerns as described in the conclusion and recommendations section of the report; there are some additional areas in which the MCEs have initiated action since the final report was written. These areas include:

1. Effective January 18, 2010, providers will only be required to use the MBHP web-based authorization system to obtain the *initial* authorization for ICC. MBHP has developed an alternative to their web-based authorization system for ICC *concurrent* authorizations for those providers who wish to use this alternative system, while allowing those providers who wish to in continue to use the web-based system the option to do so. MBHP is aggressively working to correct the technology glitches and address provider concerns with their system and plans reintroduce an improved version of their system at some point in the future.

2. In response to provider concerns that the CSA Statewide Meeting was too frequent, the meeting schedule has been reduced to every other month beginning in January 2010.

3. In response to provider feedback, the BMCHP, Fallon, NHP, and Network Health have extended the initial authorization parameter for Intensive Care Coordination (ICC) and Family Support and Training (FS&T) to 42 days in an effort to reduce administrative burden on providers to obtain authorization extensions.